Diagnosing Children with Mental Health Difficulties:
Benefits, risks and complexities

CFCA webinar – 2 August 2018

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Please note: The views expressed in this webinar are those of the presenters, and may not reflect those of the Australian Institute of Family Studies, or the Australian Government.
Disclosure

No relevant pharmaceutical industry financial relationships to declare.

Member of “Healthy Scepticism”

www.healthyscepticism.org

“Improving health by reducing harm from misleading drug promotion.”
Australian Institute of Family Studies (AIFS)

• Rhys Price-Robertson, AIFS
  • Requested me to present this webinar
  • Recently published his paper:
    • “Diagnosis in child mental health: Exploring the benefits, risks and alternatives”
  • Key messages:
    • Diagnostic labels can be important and helpful
    • DSM-III (1980) created a common language for defining mental health disorders
    • DSM-5 or ICD-10 are used in Australia — “both focus on overt symptoms rather than underlying causes or surrounding social context.”
    • Critics argue: pathologize normality, decontextualize problems, lack validity, culturally insensitive
    • Evidence of overdiagnosis of certain mental health conditions in children due to converging factors including influence of pharmaceutical industry
    • “This paper takes the view that current diagnostic systems are best seen not as scientific certainties, but rather as cultural tools used to understand different varieties of psychological distress and impairment.”
Cough disorder: an allegory on DSM-IV

Peter I Parry

The DSM-IV is more a reliable descriptive nomenclature than a valid classification of diseases

MJA • Volume 191 Number 11/12 • 7/21 December 2009
The problem with the DSM

The astute reader may by now have guessed that my “dream” is an allegory about attention deficit hyperactivity disorder (ADHD), and that, by corollary, the “DSM of human noises” is the *Diagnostic and statistical manual of mental disorders* published by the American Psychiatric Association, currently in its fourth edition.¹ The DSM is sometimes referred to as psychiatry’s bible. However, like the Bible, it should be mainly read as descriptive, not literal, truth.

The problem dates primarily from 1980 and the publication of the DSM-III. At the time, psychiatric terminology suffered from a different problem — psychiatrists using the same labels for different conditions; in particular, schizophrenia, which was over-diagnosed in the United States compared with Europe (and Australasia).² The DSM-III devised “operationalised criteria” — lists of symptoms to define descriptive “disorders”, so that everyone would at least know what behaviour was being described when a term like “schizophrenia” was used. Reliability is a necessary step on the road to validity. The DSM-III brought about a more reliable nomenclature and a more robust definition of syndromes, a vital prerequisite for psychiatric nosology (the branch of medical science dealing with the classification of diseases) to advance. However, the DSM-III was not meant to be read as a valid classification of diseases, even though it aspired towards that goal. Diagnoses in other areas of medicine also vary in
History of psychiatric nosology

- Emil Kraepelin
  - 1856 – 1926
  - defined disorders by phenomenology and clinical course
  - disease model
  - dementia praecox (SZ) & manic-depressive psychosis
  - 1980 DSM-III = triumph of “neo-Kraepelinians”

- Adolf Meyer
  - 1866 – 1950
  - “mental disorders emerge out of lives”
  - “psychobiology” = forerunner of biopsychosocial model
  - “case formulation” better than diagnostic label
  - DSM-I and DSM-II reflected Meyer’s influence – many “Reactive” states described.
• …psychiatry, at least in its American guise, was dominated by psychoanalysis…Through the 1960s, its hold over the profession and the public imagination steadily grew.
• departments of psychiatry at major medical schools were headed by psychoanalysts.
• The “refrigerator mother” was blamed for the seeming epidemic of schizophrenia.
“A Psychiatric Revolution”
The Lancet Apr 2010

• (The NIMH) proclaimed the 1990s “the decade of the brain”. A simplistic biological reductionism increasingly ruled the psychiatric roost.

• Patients and their families learned to attribute mental illness to faulty brain biochemistry...

• It was biobabble as deeply misleading and unscientific as the psychobabble it replaced, but as marketing copy it was priceless.
Leon Eisenberg
Chair American Psychiatric Association Section of Child Psychiatry
(amongst innumerable posts and honours)

Brainless Psychiatry
v
Mindless Psychiatry
Factors “dumbing down” psychiatry:
• DSM ‘deification’ & fundamentalism
• Increased service demands & managerialism
• Influence of pharmaceutical industry & consumerism
• Misunderstanding of evidence-based medicine
“A Psychiatric Revolution”
The Lancet Apr 2010

• …counter-revolution (against psychoanalysis)… primary weapon was…an anti-intellectual system published in book form: a check-list approach to psychiatric diagnosis and treatment…

• …the *Diagnostic and Statistical Manual of Mental Disorders*

• proliferate pages and disorders, like the *Yellow Pages* on steroids.
Pre- DSM-III

- Spitzer (head DSM-III task force)
  - “eliminate neurosis because… psychoanalytic meaning”
  - his mother had poor outcome from psychoanalysis

- Fink (token psychoanalyst on task force)
  - “DSM-III process was…highly prejudiced…skewed to a phenomenological and descriptive point of view and quite anti-psychodynamic.”

Quoted in “Shyness: how normal behavior became a sickness” Lane, 2007.
DSM-III (1980)

• Spitzer (head DSM-III task force)
  • “eliminate neurosis because… psychoanalytic meaning”
  • his mother had poor outcome from psychoanalysis

• Fink (token psychoanalyst on task force)
  • “DSM-III process was...highly prejudiced...skewed to a phenomenological and descriptive point of view and quite anti-psychodynamic.”

Quoted in “Shyness: how normal behavior became a sickness” Lane, 2007.
DSM itself has modest (in practice overlooked) claims:

• “generally atheoretical stance” (with respect to aetiology)
  • is designed for research, caution needed clinically and not appropriate for forensic/insurance purposes
    • introduction to DSM-III.

• “not to be used in a cookbook fashion”
  • introduction to DSM-IV.
“A Psychiatric Revolution”

The Lancet Apr 2010

• …drug money has come to dominate psychiatry. It underwrites psychiatric journals and psychiatric conferences (where the omnipresence of pharmaceutical loot startles the naive outsider)…

• …many of those whose careers it fosters become shills for their paymasters...

• The very categories within which we think…are manipulated and transformed to match the requirements of the psychiatric marketplace…
From Evidence-based Medicine to Marketing-based Medicine: Evidence from Internal Industry Documents

Glen I. Spielmans · Peter I. Parry

Received: 2 October 2009 / Accepted: 15 December 2009
© Springer Science+Business Media B.V. 2010

Abstract While much excitement has been generated surrounding evidence-based medicine, internal documents from the pharmaceutical industry suggest that the publicly available evidence base may not accurately represent the underlying data regarding its products. The larger issue is how do we face the outside world when they begin to criticize us for suppressing data...

AstraZeneca publications manager in internal email 6 Dec 1999.
ZY100035541  Olanzapine Lifeplan

- The “Safer Clozapine”
- Market is Schizophrenia.
- No mention of bipolar or dementia.
ZY201548768  Betting the Farm

• Prozac patent due to expire August 2001.
The company is betting the farm on Zyprexa … the ability of Eli Lilly to remain independent and emerge as the fastest growing pharma company of the decade depends solely on our ability to achieve world class commercialization of Zyprexa

If we succeed, Zyprexa will be the most successful pharmaceutical product ever … we will have made history
Bipolar Vision of Product Evolution

To be a leader in the bipolar market, Zyprexa will need to be viewed as *true mood stabilizer*. A *true mood stabilizer* will work in acute manic episodes without inducing depression, acute bipolar depression without inducing mania, and protect the patient from future episodes of mania or depression.
<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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<tbody>
<tr>
<td>• Efficacy in manic &amp; psychotic symptoms of an acute manic or mixed episode</td>
<td>• Weight gain</td>
</tr>
<tr>
<td>• Efficacy in rapid cycling bipolar patients</td>
<td>• Higher cost (esp. vs. Lithium/Depakote)</td>
</tr>
<tr>
<td>• Efficacy in depressive symptoms in patients with non-affective psychosis</td>
<td>• Only acute mania data/indication @ launch</td>
</tr>
<tr>
<td>• Excellent safety profile - toxicity, drug interactions</td>
<td>• Lack of maintenance or depression data</td>
</tr>
<tr>
<td>• QD dosing &amp; no titration for most patients</td>
<td>• No injectable form available at launch</td>
</tr>
<tr>
<td>• Only antipsychotic w/ an indication for bipolar</td>
<td>• Lack of comparative data (lithium, haloperidol, Depakote)</td>
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<tr>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
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<td>• Unsatisfied market - Huge potential for increase in sales/value to Zyprexa &amp; Lilly</td>
<td>• New atypicals riding Zyprexa coat tails.</td>
</tr>
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<td>• Chance to further boost the brand</td>
<td>• Not currently perceived as a mood stabilizer or a candidate for first-line treatment of bipolar disorder</td>
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<tr>
<td>• Capitalize on the success in treating psychosis</td>
<td>• Increased number of competitors - anticonvulsants &amp; atypicals</td>
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<td>• Leverage psychosis sales w/ a 2nd indication and proven efficacy in an mood disorder.</td>
<td>• Increased price competition restrictive formularies</td>
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<td>• 1st antipsychotic to bipolar market - opportunity to further blunt the competition</td>
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<td>• Change the bipolar treatment paradigm</td>
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<tr>
<td>• ROC</td>
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Summary

- We should take significant organizational pride in Zyprexa's success to date.
- However, as the environment becomes increasingly competitive we must continue to work hard and together.
- Zyprexa is a profound corporate opportunity.
- Bipolar is an opportunity equal to our top NCE's. Can we launch and grow it properly in the face of [redacted].
- Alignment, communication, and effective implementation are essential.
Expand our market by redefining how primary care physicians identify, diagnose and treat complicated mood disorders (i.e. Bipolar Disorder)
Email (2003) from Eli-Lilly Executive Vice-President for corporate development (later company CEO) reported in *New York Times* Mar 2008

• “The fact we are now talking to child psychs and peds and others about Strattera means that we must seize the opportunity to expand our work with Zyprexa in this same child-adolescent population”
“Psychiatric Diagnosis Gone Wild: The 'Epidemic' Of Childhood Bipolar Disorder”

• Emeritus Prof Allen Frances – in *Psychiatric Times* 2010

• As Chair of the DSM-IV Task Force I bear partial responsibility for two other false "epidemics"--of attention-deficit and autistic disorders.

• “Thought leading” researchers encouraged child psychiatrists to ignore the standard bipolar criteria…Then enter the pharmaceutical industry – not very good at discovering new drugs, but extremely adept at finding new markets for existing ones.
Controversy in American public media

- Death of Rebecca Riley, 13th Dec 2006, age 4.
- Diagnosed ADHD age 28 months + PBD shortly after.
- Clonidine, Quetiapine, Valproate.
- Parents gave decongestants + extra clonidine.
- Coroner: chronic organ damage from meds.
• “Max”
• “One family’s struggle to raise a troubled son.”
• 38 psychotropics from age 2 to age 10.
‘Diagnosis upcoding’ for insurance reasons

• From USA TODAY 1st May 2006:

"With some companies, the only thing they reimburse for is prescribing. There's little or no therapy,"

- Ronald Brown, editor Journal of Pediatric Psychology and dean at Temple University.
“Corpricare”

• “managed care should be called corpricare – caring for the profits of corporations not the legitimate psychiatric needs of employees and their families”

Prof Harold Eist, president APA in 1990s
Reification

Reification is the process where giving a concept, construct or process a name generally results in the assumption it has ontological existence as a genuine entity or ‘thing’.

The introduction to DSM-IV offers cautions about absolute reification of psychiatric diagnoses: “there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries” (p. xii).
Reification

“Reification of the paediatric bipolar hypothesis in the USA.”

Parry, Allison, Bastiampillai

*The Lancet Psychiatry, January 2015*

- Diagnostic upcoding factors drove premature declaration of a new diagnostic category for children
• In your opinion, PBD in the USA at present is overall...
Number PBD presentations at child & adolescent psychiatry conferences 2009

• AACAP – Hawaii, USA = 40 (+ 6 SMD + 6 trad bipolar)
• RANZCP FCAP – Queenstown, New Zealand = 0
• ESCAP – Budapest, Hungary = 0
A Comparison of American and English Hospital Discharge Rates for Pediatric Bipolar Disorder, 2000 to 2010

Anthony James, MD, Uy Hoang, MD, Valerie Seagroatt, MSc, Joe Clacey, MD, Michael Goldacre, MD, Ellen Leibenluft, MD

Objective: Controversy exists over the diagnosis and prevalence of pediatric bipolar disorder (PBD). Although several small surveys suggest that the rate of the PBD diagnosis in clinical settings is higher in the United States than in other countries, no comprehensive cross-national comparisons of clinical practice have been performed. Here, we used longitudinal national datasets from 2000 to 2010 to compare US and English hospital discharge rates for PBD in
ASD epidemic in Australia

- Special Medicare rebates for paediatricians, psychologists, speech pathologists.
- Welfare parent/carer payments.
- Schools extra classroom assistance.

The autism spectrum disorder ‘epidemic’: Need for biopsychosocial formulation

Soumya Basu\textsuperscript{1} and Peter Parry\textsuperscript{2}
VIEWPOINT

Public services for children with special needs: Discrimination by diagnosis?

Michael McDowell and Mick O'Keeffe
Child Development Network, South Brisbane, Queensland, Australia

Abstract: In July 2011, the Australian federal government announced expansion of early intervention funding. Children diagnosed with cerebral palsy, Down syndrome, Fragile X syndrome and hearing and vision impairments are now eligible in addition to the existing funding for children diagnosed with autistic disorders. By deciding who gets the funding according to a set of accepted diagnoses, many children with equivalent if not greater levels of early intervention special need are excluded. In this viewpoint, we consider the fairness of this approach, and argue that while it may make sense from a political point of view, it is hard to justify, and possibly even discriminatory, from clinical, ethical and legal perspectives.
Tim Fischer,
Deputy PM, Australia 1996-1999

- Later Ambassador to the Vatican
- PM John Howard 2007:
  - “motivation for the (new funding for autistic children) package” from the Fischer family
- Very good intentions
- Severe ASD is a huge strain on families!
ANNOTATION

Diagnosis in developmental–behavioural paediatrics: The art of diagnostic formulation

Mick O’Keeffe and Caroline Macaulay
Child Development Program, Royal Children’s Hospital Health Service District, Brisbane, Queensland, Australia

Abstract: This paper considers diagnostic frameworks in developmental–behavioural paediatrics. The purpose of a diagnostic assessment is reviewed, and the use of categorical diagnoses is explored. A multi-level process of diagnostic formulation is outlined, highlighting the importance of a comprehensive focus on presenting symptoms, neuropsychological constructs, biological factors and environmental influences. The axis of time, developmental benchmarks and the enhancement of resilience are discussed as part of the diagnostic formulation framework. Limitations imposed on diagnostic practice by systemic and personal factors are reviewed. Implications for training and practice are discussed.

Key words: developmental–behavioural paediatrics; diagnosis; diagnostic formulation; diagnostic label.

Paediatrician Dr X settles in for an afternoon of consulting. The GP’s letter on the desk advises that J, a new patient, is failing at school and constantly in trouble, and alludes to ‘problems at home’. The school principal has informed J’s mother that J ‘can’t get help without a diagnosis’. A glance at the diary reveals a 40 minute allocation for this appointment. Dr X wonders how best to approach a case such as this.

Diagnostic practice in developmental–behavioural paediatrics (DBP), like other areas of medicine, has been strongly influenced by the biomedical model of practice. This model attempts to relate symptoms to the underlying biological cause.\(^1\)–\(^3\) The focus is on deficits or illness, and the patient is viewed as a passive recipient of treatment.\(^4\) Engel’s biopsychosocial model signified a shift away from a narrow biomedical understanding of assessment and intervention to move from the individual alone to include his/her family situation and function within other environments (e.g. education).\(^12\)

Nowhere is this more important than in the field of DBP, yet it remains a struggle to fully embrace these ideas at the coalface of clinical paediatric practice. Clinicians can tend to orientate assessments towards more familiar developmental domains (e.g. language, motor co-ordination, cognitive abilities), with less attention given to areas such as emotional regulation, social interaction, behaviour and the family environment.\(^13\) This is an uncomfortable situation, given the importance of these factors in the evolution of maladaptive consequences, including more severe mental health sequelae. Another source of disquiet is a personal observation that much of our professional time and energy is soaked up by ‘diagnostic
DSM neglects the relational/subjective

WAYNE H. DFENTON  Am J Psychiatry 164:8, August 2007

Editorial

As the American Psychiatric Association committees begin formal work on DSM-V, we welcome brief editorials on issues that should be considered in its formulation.

Issues for DSM-V: Relational Diagnosis: An Essential Component of Biopsychosocial Assessment

We are hardwired to seek out attachment, and relational processes will always be an essential part of the human experience (1). Although DSM strives to apply the biopsychosocial model, there is a notable and strikingly absent consideration of the role of relational processes and disorders in the development, maintenance, and manifestations of mental disorders. The development of DSM-V offers an opportunity to correct this deficiency, and such a correction is warranted and vital.
Infants are integrated into daily life, with continuous contact and breast feeding.

Slide courtesy Prof J McKenna

the !Kung San Bushman
Mother infant holding

The Welsh Shawl

Tradition of long holding and carrying of infants was in West too.
Infant mirroring behaviour
Infant rhesus monkey mirroring behaviour
Ethology – the effects of severe neglect

- Harlow’s monkeys
- Cling to the toweling ‘mother’ not the wire ‘mother with milk’
- Attachment (love) the primary drive for infants
The neuroscience of attachment and trauma
Importance of early intervention and child protection

From Prof Bruce Perry’s website: www.childtrauma.org
Paediatric Bipolar Disorder – Are Attachment and Trauma Factors Considered?

Peter I. Parry
Flinders University
Australia

1. Introduction

1.1 Debate over the boundaries of bipolar disorder

Significant debate and controversy surrounds the boundaries of Bipolar Disorder (BD). Proponents of a broader category for BD within psychiatric nosology (e.g. Akiskal, 2007) argue that more limited episodes of mood instability in both time and severity belong on a broader bipolar spectrum. Others (e.g. Paris, 2009) contend that hypomanic symptoms that fail to meet full DSM-IV or ICD-10 criteria for time or severity for BD-I and some BD-II disorders are more likely to represent reactive affective states related to environmental and relational stressors and/or personality traits or disorders. A widening of what constitutes BD beyond traditional concepts of manic-depressive illness has been related to historical and social factors impacting on psychiatric nosology (Healy, 2010).
If labelling symptoms can go so astray...

• Need grounding in established theories:

Attachment Theory
Ethology
Neurophysiology of Stress
Evolutionary Biology/Psychology
Family Systems Theory
Genetic knowledge – where well replicated
Schauer & Elbert (2010) Dissociation Following Traumatic Stress: Etiology and Treatment

**Type 1:** “uproar” sympathetic activation
- dizziness
- lightheaded
- palpitation
- dry mouth
- numbing
- muscle tension
- feelings of irreality

**Type 2:** “shut-down” para-sympathetic activation
- bradycardia
- vasodilatation
- hypotension
- drop in arousal
- surrender
- cognitive failure
- numbing of all emotions

**1. Freeze**
- (attentive immobility: “orienting response”)

**2. Flight**
- (defense reaction)

**3. Fight**
- (defense reaction)

**4. Fright**
- tonic immobility (unresponsive immobility)
- tachycardia, vasoconstriction, hypertension, hyperalertness
- high emotional arousal
- fear largely repressing anger
- i.a. assultive breakout followed by immobility
- -> faster onset and termination of the immobility

**5. Flag**
- (defense reaction)

**6. Faint**
- (defense reaction)

**Increasing dissociation during cascade progression**
Defensive Responses to Threat
A model I use for parents and teens to put symptoms in evolutionary biological context

Sympathetic (stress/survival) activation = “Amygdala Hijack” (frontal lobes turned down/off)
• Avoidance
• Attentive Immobility
• Appease (if less threatened in social relationship)
  • ‘silly, giddy and goofy’, nervous excitement, histrionic behaviour
• Flight
• Fight
• Tonic Immobility (Freeze ‘Fright’)

Parasympathetic (peaceful, rest, digest and grow) nervous system recovery after threat gone
• Recuperation
• Proximity seeking – according to attachment security/insecurity pattern
  • Secure, Avoidant, Ambivalent-Reactive, Disorganised attachment patterns
• In insecure patterns – no reset to relaxed parasympathetic baseline
  • Agonic relationships based on power and avoidance-approach dilemma
  • “Hostile dependency”
“When wounds from infancy collide: The mother child relationship as trauma, trigger, and treatment.”

- The nature of complex trauma in dyadic relationships.
- Approach-avoidance dilemmas and patterns.
- Exposure and response-prevention in dyadic parent-child therapy.
Because childhood abuse occurs during the critical formative time when the brain is being physically sculpted by experience, the impact of severe stress can leave an indelible imprint on its structure and function. Such abuse, it seems, induces a cascade of molecular and neurobiological effects that irreversibly alter neural development." (p.56) Martin H. Teicher. *Scars that won't heal: the neurobiology of child abuse*. Scientific American, March 2002. pp.54-61.
Underused and Rejected Diagnoses

• Reactive Attachment Disorder
  • Of infancy and early childhood

• Disinhibited Social Engagement Disorder
  • Relates to severe attachment trauma

• Developmental Trauma Disorder
  • Proposed by Van der Kolk et al
  • Rejected by DSM committees

• Parent-child relational problem
  • DSM ‘V’ codes
  • ICD-10 F code diagnosis “Other Problems Related to Severe Stress” and contextual issues listed in Z, R & X codes
V codes in DSM-5

Diagnostic Criteria for Relational Problems

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Alternatives/improvements to DSM

- “The 4 perspectives”
  - John Hopkins University
    1. Disease
    2. Dimension
    3. Behaviour
    4. Life story
Four Perspectives Relate But Not Equivalent to DSM/ICD Syndromal Symptom Model

Some Examples:

• Disease (including abnormal neurological function):
  • ADHD; Developmental delays; Foetal Alcohol Spectrum Disorder; Trisomy 21; Antineuronal antibodies; Bipolar disorder; Schizophrenia; Autism; Anorexia Nervosa

• Dimension:
  • ADHD; Developmental delays; CD; Mood lability; Anxiety disorders
  • *Externalising v Internalising* Disorders

• Behaviour:
  • ADHD; ODD; CD; Mood lability; Eating disorders, Addictions (e.g. computer game addiction)

• Life Story:
  • ADHD; ODD; CD; Mood lability; Eating disorders; Anxiety disorders; Complex trauma; Reactive Attachment Disorder etc including avoidant ASD like traits; Language and learning delays
Four Perspectives Still Not Enough: Transactional-Developmental Perspectives

• Have to synthesize the data from all domains
• Children and adolescents are growing and changing
• Concept of Equifinality or Multicausality
  • Different stressors and contexts in different children’s development may end up looking the same symptomatically – a syndromal diagnosis like ‘ADHD’, ‘ODD’/’CD’, milder ‘ASD’, ‘Depression’, & in USA ‘PBD’ – may need differing forms of treatment addressing the underlying causative pathways.
• Also Multifinality from a single causative stressor
  • Inborn temperament may lead similarly abused siblings down either internalizing or externalizing disorder pathways.
Informational Reductionism

data \neq \text{information}

\text{information} \neq \text{knowledge}

\text{knowledge} \neq \text{understanding}

\text{understanding} \neq \text{wisdom}

Clifford Stoll

• Reliability \neq \text{Validity} !!

• Rating scales/questionnaires trumping clinical experience, in-depth case reports and tradition?
  » In research
  » In journals
  » In clinical practice

• Where are time consuming but invaluable child-centred playroom assessments?
Albert Einstein
– plaque he hung over his door at Princeton

“Not everything that counts can be counted, and not everything that can be counted, counts.”
The DMM

A Dynamic-Maturational Model of Attachment

Patricia M. Crittenden

FIGURE 2
The Dynamic-Maturational Model of Attachment.
The PDM

- A collaborative effort of the
  - American Psychoanalytic Association
  - International Psychoanalytical Association
  - Division of Psychoanalysis (39) of the American Psychological Association
  - American Academy of Psychoanalysis and Dynamic Psychiatry
  - National Membership Committee on Psychoanalysis in Clinical Social Work

- The PDM is a diagnostic framework that describes both the deeper and surface levels of an individual's personality, emotional and social functioning, and symptom patterns.

- The PDM opens the door to improvements in diagnosis and treatment of mental health disorders.
Spitzer’s mea culpa

• “Relentless in its logic, Horwitz and Wakefield’s book forces one to confront basic issues that cut to the heart of psychiatry. It has forced me to rethink my own position…

• The very success of the DSM and its descriptive criteria… has allowed psychiatry to ignore basic conceptual issues… especially the question of how to distinguish disorder from normal suffering.”

• “DSM diagnostic criteria… ignored any reference to the context in which they developed.”

Robert Spitzer (former chair DSM-III)

Foreword to book:

“The Loss of Sadness: How psychiatry turned normal sorrow into depressive disorder”
Backlash against biomedical reductionism

• The Psychologist May 2007

– Magazine of British Psychological Society.

– “In an attempt to emulate general medicine psychiatry has attempted to distinguish between different psychiatric diseases, each assumed...own specific pathology. ...the story is not that simple.”

J. Moncrieff, psychiatrist
In sum, we have serious reservations about the proposed content of the future DSM-5, as we believe that the new proposals pose the risk of exacerbating longstanding problems with the current system. Many of our reservations, including some of the problems described above, have already been articulated in the formal response to DSM-5 issued by the British Psychological Society (BPS, 2011) and in the email communication of the American Counseling Association (ACA) to Allen Frances (Frances, 2011b).

In light of the above-listed reservations concerning DSM-5’s proposed changes, we hereby voice agreement with BPS that:

- “...clients and the general public are negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation."

- “The putative diagnoses presented in DSM-V are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgments, with little confirmatory physical 'signs' or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations.”

- “... [taxonomic] systems such as this are based on identifying problems as located within individuals. This misses the relational context of problems and the undeniable social causation of many such problems.”
Some further reading/watching


• Batstra & Frances (2012). Diagnostic inflation: Causes and a suggested cure. *Journal of Nervous & Mental Disease* 200: 474-479


• Bracken et al. (2012). Psychiatry beyond the current paradigm. *British Journal of Psychiatry* 201: 430-434

Biopsychosocial Case Formulation

Figure A.11.1 Integrating the data as a diagnostic formulation: the diagnostic matrix

<table>
<thead>
<tr>
<th>Predisposition</th>
<th>Precipitation</th>
<th>Pattern</th>
<th>Perpetuation</th>
<th>Potential</th>
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<tbody>
<tr>
<td>Physical</td>
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<tr>
<td>Psychological</td>
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<tr>
<td>Family/Social</td>
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It is as important to know the man who has the disease as it is to know the disease the man has.

Hippokratês
The “Four Session Assessment”

- Traditional training in child psychiatry (lost in rush to ‘time efficiency’ in recent years)

1. See whole (if possible) family together
   - Genogram to chat around – build rapport, establish confidentiality and goals, observe interactions

2. See parents on their own
   - Gain intergenerational family history and detailed developmental history

3. Playtherapy room assessment with younger child/ interview with adolescent
   - (ideally two sessions of this with younger children)

4. Feedback to family of the diagnostic formulation

- Meanwhile gather information from other stakeholders such as past and current providers and especially the school
Psychiatric Diagnosis: Answers, Educated Guesses or Good Questions?

Perhaps should also have added: “or Blinkered Short Cuts to Disaster.”

In truth, diagnostic labels can be any of the above – depends on the individual client and the historical and contemporary context of their life and relationships – and the skill and time spent of the diagnostician.
What is behind the symptom”

Karl Menninger, 1963
Return to our allegorical dream of cough disorder

The dream ended happily. The lad and his parents came to understand that cough disorder was not a diagnosis but a description, and that his real problem — mild asthma — required a different medication, and then no medication at all when his parents stopped smoking in his presence. We had tried Supressalin at one point, but it gave only short-term relief.

The parents and I even had a more philosophical discussion about how the third edition of the DSM of human noises focused on defining human noises descriptively, at a time when some doctors talked about “cough” when they really meant “sneeze”, “burp” or “hiccup”, and how that was a good development back in 1980. But we also discussed how, as an atheoretical descriptive system, it generally gives no information about underlying causes, and how important the search for real causes is; this is something the family now appreciates.
Continue the conversation

Questions?

Please submit questions or comments on the online forum following today’s webinar: www.aifs.gov.au/cfca/news-discussion